

**BEFORE THE ARIZONA BOARD OF OSTEOPATHIC EXAMINERS**  
**IN MEDICINE AND SURGERY**

IN THE MATTER OF:	)	Case No.: DO-15-0266A
	)	
DAVID MINOR, D.O.	)	FINDINGS OF FACT,
Holder of License No. 2321	)	CONCLUSIONS OF LAW, AND
	)	ORDER FOR DECREE OF CENSURE AND
	)	PROBATION
For the practice of osteopathic medicine in	)	
the State of Arizona	)	

In November 2015, the Arizona Board of Osteopathic Examiners (hereafter "Board") received a complaint against the license of David Minor D.O. (hereafter "Respondent"). On November 30, 2015, the Board noticed Respondent of an investigation into that complaint. In January 2016, the Board received Respondent's responses to the complaint.

The Board duly noticed a Case Review on April 9, 2016. The Board moved the matter to an Investigative Hearing and requested the Board's Medical Consultant to perform a chart review based on a Pharmacy audit review. The Board noticed an Investigative Hearing on this matter for January 21, 2017, but the matter was continued for the purpose of obtaining additional records. The Board held an Investigative Hearing on February 25, 2017. Respondent appeared personally and on his own behalf.

After hearing testimony from the Respondent and considering the documents and evidence submitted, the Board voted to impose probation with a practice restriction for five years prohibiting Respondent from prescribing and ordered Respondent to undergo a practice assessment.

Respondent retained counsel and requested a Rehearing. On May 6, 2017, the Board granted the Rehearing and ordered an additional chart review.

The Board held a Rehearing of this case on February 24, 2018. After hearing testimony from the Respondent and counsel, Mr. Steve Myers, and considering the documents and

1 evidence submitted, the Board voted to enter the following Findings of Fact, Conclusions of  
2 Law, and Order for a Decree of Censure and Probation.

### 4 **JURISDICTIONAL STATEMENTS**

5 1. The Board is empowered, pursuant to A.R.S. § 32-1800 *et seq.*, to regulate the  
6 practice of osteopathic medicine in the State of Arizona, and the conduct of the persons  
7 licensed, registered, or permitted to practice osteopathic medicine in the State of Arizona.

8 2. Respondent is the holder of License No. 2321 issued by the Board for the  
9 practice of osteopathic medicine in the State of Arizona.

### 10 **FINDINGS OF FACT**

11  
12 3. On November 17, 2015, the Board received a complaint from the daughter of  
13 patient, C.C., who reported Respondent was prescribing a number of prescriptions that she  
14 believed could cause harm to C.C.

15 4. The Board's medical consultant performed a review of C.C.'s chart and found  
16 that urine drug screens were not done, no consults or referrals were documented in the  
17 medical records, no laboratory results were listed in the medical records, and no x-rays or  
18 diagnostic studies were documented in the records. In addition, the medical record did not  
19 contain documentation of a pharmacy audit or a pain contract nor did the medical record  
20 indicate the amount of controlled substances that were prescribed to C.C.

21 5. The Board's medical consultant completed a chart audit on eight (8) of  
22 Respondent's patients.

23 6. The medical consultant noted the following concerns:

24 A. Previous medical records were not available for review for any of the  
25 patients.

- 1 B. Controlled substance agreements were not signed with any of the  
2 patients.
- 3 C. A pharmacy audit was not documented for any of the patients.
- 4 D. Urine Drug Screens were not documented/performed for any of the  
5 patients.
- 6 E. Documentation of the prescribed controlled substance was not always  
7 included in the medical record. The dosages and amount prescribed  
8 were not in any of the patient's records.
- 9 F. Respondent prescribed opioids and benzodiazepines at the same time  
10 for the following patients: M.M. (DOB 2/15/83), M.M. (DOB 7/23/72),  
11 C.P. (DOB 7/1/62), T.T. (DOB 1/8/65), and D.C. (DOB 12/11/72).
- 12 G. Respondent prescribed two different benzodiazepines at the same time  
13 to the patients C.P. (DOB 7/1/62) and D.C. (DOB 12/11/72).
- 14 H. A patient was started on Adderall for ADD without a workup and it was  
15 noted to be used to help control her appetite. C.A. (DOB 7/25/84).
- 16 I. With the exception of patients D.B. (DOB 8/10/59) and C.A. (DOB  
17 7/25/84), the patients were referred to multiple specialists but the  
18 consults were not included in the medical record.

19 7. Respondent fell below the community standard of care in the prescribing of  
20 controlled substances. The community standard involves an evaluation of a patient's medical  
21 history, presenting complaint, appropriate physical exam, review of previous diagnostic testing,  
22 urine drug screens, pharmacy queries, and documentation in the medical records of the same.

23 8. Respondent had a lack of documentation in the medical records to evidence  
24 proper care and management of patients being treated with controlled substances.

25

1           9.     On May 6, 2017, the Board directed staff to conduct a second chart review with  
2 particular attention to Respondent's prescribing practices after November 2016. Ten charts  
3 were reviewed, five random charts and five charts that were previously reviewed.

4           10.    The Board's medical consultant found several aggravating factors. Respondent  
5 did not refer several patients to pain management until after the Investigative Hearing in  
6 February of 2017. In many cases controlled substance agreements were not signed until the  
7 patient had been seen for several years and were finally signed in 2016. In many cases the  
8 CSPMP was not queried for many years and were finally queried in 2016. The Board's medical  
9 consultant also found several mitigating factors. Physical exams were completed at each visit,  
10 laboratory was ordered, diagnostic studies were performed in all patients, and after November  
11 2016, the controlled substance amount and dose were always documented in the medical  
12 record and pharmacy audits were documented.

13           11.    The findings above paragraph 4 through 9 reflect the results of a board audit of  
14 Respondent's charts prior to February 2017 and set forth a number of deviations from the then  
15 current standards of care for prescribing, which resulted in the Board's imposition of a  
16 restriction on his license prohibiting him from prescribing for five years during its Board  
17 meeting of February 25, 2017.

18           12.    Respondent then retained counsel and requested a Rehearing of the case. On  
19 May 6, 2017 the Board, based upon legal reasons, the Board granted Respondent's request for  
20 a Rehearing and rescinded the restriction and ordered an additional audit of Respondent's  
21 charts for care that he provided to patients after November 2016.

22           13.    In the meantime in late April of 2017, Respondent completed the PACE three-  
23 day intensive prescribing course. (PACE is affiliated with the University of California, School of  
24 Medicine at San Diego.)  
25

1           14.     On February 24, 2018, Respondent appeared before the Board with counsel, Mr.  
2 Steve Myers, for review, discussion and action on the Rehearing of this matter. The Board's  
3 Medical Consultant provided a summary of the additional chart review conducted on ten (10)  
4 patients. Respondent and his attorney made a statement before the Board. Respondent  
5 apologized to the Board for not previously knowing the then current standards of care for  
6 prescribing controlled substances. Respondent stated that he had not realized that he had not  
7 known the current standards.

8           15.     Respondent was employed during the first half of 2017 by a group practice until  
9 termination from his employment effective March 29, 2017. He became re-employed by  
10 another group on August 15, 2017.

11          16.     Before the hearing of February 24, 2018, Respondent presented to the Board the  
12 PMP Prescriber Reports regarding his prescriptions for controlled substances for the periods of  
13 1/1/2017 to 6/30/2017 ("First half of 2017") and 7/01/2017 to 12/31/2017 ("Second Half of  
14 2017"). The Board considered this information and Mr. Myers' statement that respondent's  
15 PMP Prescriber Reports reflect that very few patients are prescribed opioids and it reflects that  
16 83% of his patients receiving opioid prescriptions, as a covering physician, were given a  
17 prescription having an MME of 50 or fewer. Mr. Myers reported that the statistics on the low  
18 durations of his prescriptions do suggest that Respondent may now be prescribing above the  
19 standard of care.

20          17.     Considering the documents and evidence submitted, Respondent's testimony  
21 regarding the significant changes made to his prescribing of controlled substances, his answers  
22 to the Board member's questions and Board member deliberations, the Board unanimously  
23 concluded to allow Respondent to continue to prescribe controlled substances without  
24 restriction, while on probation, with periodic chart reviews.

1 **CONCLUSIONS OF LAW**

2 18. The conduct described above is a violation of unprofessional conduct pursuant  
3 to A.R.S. § 32-1854(6), which states "Engaging in the practice of medicine in a manner that  
4 harms or may harm a patient or that the board determines falls below the community  
5 standard."  
6

7  
8 19. The conduct described above is a violation of unprofessional conduct pursuant  
9 to A.R.S. § 32-1854(38), which states "Any conduct or practice that endangers the public's  
10 health or may reasonably be expected to do so."  
11

12 **AGGRAVATING FACTOR**

13 20. After reviewing this matter, the Board considered Respondent's disciplinary  
14 history in case 1249. In June 1991, the Board issued an Order to Respondent involving  
15 inappropriate prescribing of controlled substances. As a result, the Board suspended his license  
16 for thirty days followed by a three (3) year period of probation that included prohibiting  
17 Respondent from prescribing controlled substances. Respondent was also required to  
18 complete CME and pay a civil penalty.  
19

20 **ORDER**

21 Pursuant to the authority vested in the Board,

22 1. **IT IS HEREBY ORDERED** that the license of David Minor, D.O, License number  
23 2321 is issued a Decree of Censure.

24 2. **IT IS HEREBY FURTHER ORDERED** that the license of David Minor, D.O,  
25 License number 2321 is placed on PROBATION for a minimum period of four (4) years from the

1 effective date of April 7, 2017. At the conclusion of four years, Respondent must petition the  
2 Board for termination of his probation and release from all terms and conditions of the  
3 probation. If the Board determines that Respondent has not complied with all the requirements  
4 of this Order the Board, in its sole discretion, may either: (a) continue the probation or (b)  
5 institute proceedings for noncompliance with this Order, which may result in suspension,  
6 revocation, or other disciplinary and/or remedial action.

8 3. **Chart Reviews:** Respondent shall cooperate and provide records for chart  
9 reviews during the period of probation. A Chart review of ten (10) patient charts shall be  
10 conducted within six (6) months of the effective date of February 24, 2018. Additional periodic  
11 chart reviews shall be conducted at a time and at the discretion of the Board's Executive  
12 Director and Medical Consultant.

14  
15 4. **Costs:** Respondent shall bear all costs incurred regarding compliance with this  
16 Order.

17 5. **Obey All Laws:** Respondent shall obey all federal, state and local laws, and all  
18 rules governing the practice of medicine in the State of Arizona.

19 6. **Ceasing Practice in the State of Arizona:** In the event that Respondent ceases  
20 to practice medicine in the State of Arizona, by moving out of state, failing to renew his license,  
21 or maintaining an Arizona license but ceasing to practice clinical medicine or administrative  
22 medicine requiring licensure, Respondent shall notify the Board that he has ceased practicing in  
23 Arizona, in writing, within 10 days of ceasing to practice. In its sole discretion, the Board may  
24 stay the terms of this Order until such time as the Respondent resumes the practice of  
25 medicine in Arizona, or may take other action to resolve the findings of fact and conclusions of  
law contained in this Consent Agreement and Order for Probation.

1           7. Failure to Comply / Violation: Respondent's failure to comply with the  
2 requirements of this Order shall constitute an allegation of unprofessional conduct as defined  
3 at A.R.S. § 32-1854(25) and proven violations may be grounds for further disciplinary action  
4 (e.g., suspension or revocation of license).

5  
6  
7 ISSUED THIS 22<sup>nd</sup> DAY OF MAY, 2018.  
8 ARIZONA BOARD OF OSTEOPATHIC EXAMINERS  
9 IN MEDICINE AND SURGERY

seal

10 By: 

11 Amber Brake, JD, MHA, FACHE, Executive Director

12  
13 **NOTICE OF RIGHT TO REQUEST REVIEW OR REHEARING**

14 Respondent may request a rehearing or review of this matter pursuant to A.R.S. § 41-  
15 1092.09. The motion for rehearing or review must be filed with the Arizona Board of  
16 Osteopathic Examiners within thirty (30) days. If a party files a motion for review or rehearing,  
17 that motion must be based on at least one of the eight grounds for review or rehearing that are  
18 allowed under A.A.C. R4-22-108(D). Failure to file a motion for rehearing or review within 30  
19 days has the effect of prohibiting judicial review of the Board's decision. Service of this order is  
20 effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a motion for rehearing or  
21 review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to  
22 Respondent.

23  
24 Original "Findings of Fact, Conclusions of Law and Order for Decree of Censure and Probation"  
25 filed this 22<sup>nd</sup> day of May, 2018 with:

Arizona Board of Osteopathic Examiners

1 In Medicine and Surgery  
2 1740 W. Adams St., Ste 2410  
3 Phoenix, AZ 85007

4 Copy of the "Finding of Fact, Conclusions of Law and Order for Decree of Censure and  
5 Probation" sent by certified mail, return receipt requested, this 22<sup>nd</sup> day of May, 2018 to:

6 Stephen Myers  
7 One Renaissance Square  
8 2 North Central Ave, Ste 1450  
9 Phoenix, AZ 85004

10 Copy of the "Finding of Fact, Conclusions of Law and Order for Decree of Censure and  
11 Probation" sent by certified mail, return receipt requested, this 22<sup>nd</sup> day of May, 2018 to:

12 David Minor, D.O.  
13 Address of record

14 Copies of this "Findings of Fact, Conclusions of Law and Order for Decree of Probation and  
15 Restriction" filed/sent this 22<sup>nd</sup> day of May, 2018 to:

16 Jeanne Galvin, AAG  
17 Office of the Attorney General CIV/LES  
18 1275 West Washington  
19 Phoenix AZ 85007 AB

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